

7572  
CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Federalsburg</b>		LENGTH OF STAY (In this place) <b>50 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>305 Holt Street</b>				STREET ADDRESS (If rural give location) <b>305 Holt Street</b>			
3. NAME OF DECEASED: (First) <b>Frank</b>		(Middle) <b>Scott</b>		(Last) <b>Bradley</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>August 12 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>May 9, 1884</b>		9. AGE last birthday <b>71</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired U. S.</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Postmaster</b>		11. BIRTHPLACE (State or foreign country): <b>Wicomico County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John S. Bradley</b>				14. MOTHER'S MAIDEN NAME: <b>Amelia (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>Mrs. Bessie C. Bradley, Federalsburg, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>154X</b>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Carcinoma of Liver</b>						2 wks.	
(B) <b>Adeno Carcinoma of Rectum</b>						4 1/2 wks.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>5/10/51</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Adeno Carcinoma of Rectum Grade I</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 12 1955</b> , 19 <b>55</b> , to <b>Aug 12 55</b> , that I last saw the deceased alive on <b>Aug 12 1955</b> , and that death occurred at <b>11:15 A</b> M, from the causes and on the date stated above.							
SIGNATURE <b>W. K. Knott</b>		M. D. <b>Federalsburg, Maryland</b>		DATE SIGNED <b>Aug. 15, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 15, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>August 15, 1955</b>		REGISTRAR'S SIGNATURE <b>Margaret H. Frampton</b>		24. FUNERAL DIRECTOR <b>J.J. Frampton and Son</b>		ADDRESS <b>Federalsburg, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1955

BUREAU V. S.

7573

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Caroline</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Caroline</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Marydel</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Marydel</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>			STREET ADDRESS (If rural give location) <u>None</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mamie</u> <u>Burris</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>8</u> <u>1</u> <u>55</u> <u>19</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>7/16/1904</u>		9. AGE last birthday: <u>51</u> Yrs. yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>James Berry</u>		
14. MOTHER'S MAIDEN NAME: <u>Emma Green</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT & ADDRESS: <u>Clarence Burris Marydel, Md.</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
171X IMMEDIATE CAUSE (A) <u>Carcinoma of Cervix uteri</u>	DUE TO	
ANTECEDENT CAUSE (B) <u>With metastases to Pelvic</u>	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Organs</u>	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 5, 1955, to Aug. 1, 1955, that I last saw the deceased alive on Aug. 1, 1955, and that death occurred at 8:20 A.M. from the causes and on the date stated above.

SIGNATURE <u>Charles X. Frazier</u> M.D.	ADDRESS <u>see above</u>	DATE SIGNED <u>Aug 3, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>Price Chaple</u>
		LOCATION (City, town, or county) (State) <u>Templeville, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>8/4/55</u>	REGISTRAR'S SIGNATURE <u>A. C. Smith</u>	24. FUNERAL DIRECTOR <u>J. E. Boulin's Funeral Home, Md.</u>
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RECEIVED  
AUG 22 1955  
BUREAU V. I.

7572

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>X</b> TOWN <b>Preston</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Preston</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>/</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <b>Mary</b> (Middle) <b>Ethel</b> (Last) <b>Fluharty</b>				<b>August 10 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	B. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>Sept. 23, 1899</b>	<b>55</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Housework</b>		<b>Home</b>		<b>Caroline County, Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Edward Patrick</b>				<b>Elma Eaton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>No</b> (If Yes, give war or dates of service)		<b>220-01-7882</b>		<b>Arthur S. Fluharty, Preston, Maryland</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Carcinoma Head. Pancreas</b>						<b>9-18 '54</b>	
ANTECEDENT CAUSE (S) <b>General Metastasis.</b>						<b>Jan. 8 '55</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9-18, 1954</b> , to <b>8-10, 1955</b> , that I last saw the deceased alive on <b>8-10, 1955</b> , and that death occurred at <b>4:55 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. E. Simon</b>				DATE SIGNED <b>Aug. 11, 1955</b>			
M. D. <b>Federalburg, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug. 13, 1955</b>		<b>Linchester Cemetery</b>		<b>Linchester, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>8-13-55</b>		<b>Cornelia W. Plummer</b>		<b>J. J. Frampton and Son, Federalburg, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

BUREAU V. S.

AUG 16 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07573

## 7575 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Federalsburg - Rural</u>		<u>Life</u>		X <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00 Near Friendship</u>				<u>Near Friendship</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
<u>Bessie</u>		<u>Mae</u> <u>Gadow</u>		<u>August 18</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 18, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Home</u>		<u>Caroline County, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Gootee</u>				<u>Amanda Marine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Herman R. Gadow, Federalsburg, Md., R.F.D.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE						<u>7 hours</u>	
(A) DUE TO <u>Acute Coronary Occlusion</u>							
ANTECEDENT CAUSE (S)							
(B) DUE TO <u>Arteriosclerotic Heart Disease</u>						<u>7 1/2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>P Diabetes Mellitus</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/18</u> , 19 <u>55</u> , to <u>8/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>55</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Jerry D. Plummer</u>		<u>Preston, Maryland</u>		<u>Aug. 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 21, 1955</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Aug 24, 1955</u>		<u>Corneha W. Plummer</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

RECEIVED

AUG 25 1955

BUREAU V. S.



7576

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>	LENGTH OF STAY (in this place) <u>8 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Laura</u>	(Middle) <u>Hazel</u>	(Last) <u>Moyer</u>	DATE OF DEATH: <u>8</u> <u>7</u> <u>55</u> <u>19</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9/29/1906</u>
9. AGE last birthday <u>48</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm. H. Saxton</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Belle Batters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-1222</u>	
17. INFORMANT & ADDRESS: <u>Roger Moyer Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of rt. breast</u>			<u>18 mon.</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Aug. 1954</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of rt. breast</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 20, 1954</u> to <u>Aug. 7, 1955</u> , that I last saw the deceased alive on <u>Aug. 6, 1955</u> , and that death occurred at <u>12:40 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Stinner</u>		DATE SIGNED <u>8/8/55</u>	
ADDRESS <u>Greensboro, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>Aug. 10 - 1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Pippin</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	

RECEIVED

AUG 17 1955

BUREAU V. E.

7577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07575

Reg. Dist.

No. 62

1. PLACE OF DEATH:

COUNTY Caroline MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Newton, Md. LENGTH OF STAY (in this place) 25 days

TOWN Newton, Md.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Ind. COUNTY Caroline

CITY (If outside corporate limits write RURAL and give nearest town) Newton, Ind.

TOWN Newton, Ind.

STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First) Bradie (Middle) Ruth (Last) Murphy

4. DATE OF DEATH Aug. 2<sup>nd</sup> 19 55

5. SEX:

F.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

6/2/1902

9. AGE last birthday:

53 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

at home

10b. KIND OF BUSINESS OR INDUSTRY:

Newton, Ind.

11. BIRTHPLACE (State or foreign country):

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Charles Fountain

14. MOTHER'S MAIDEN NAME:

Guanda Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Harry Murphy (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

976x  
Immediate cause

(a) Hemorrhage - shock

INTERVAL BETWEEN ONSET AND DEATH

immediate

Antecedent cause(s)

(b) Gun shot wound to head

"

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 7-2-55 1:45 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Gun shot wound to head

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Lawson D. George

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

M. D.

ASSISTANT MEDICAL EXAM.

8/4/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/4/55

Lawson D. George

Concord Cemetery, Newton, Ind.

Ind.

8/4/55

Lawson D. George

J. Edgar Moore & Son, Newton, Ind.

Newton, Ind.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05033

RECORDS EXAMINERS (WHITE) CASE OF DEATH  
NATIONAL BUREAU OF HEALTH STATISTICS

BUREAU V. S.

AUG 10 1955

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7573

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07576  
Reg. Dist.

No. 62

1. PLACE OF DEATH COUNTY <u>Caroline</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Denton</u> TOWN <u>Denton</u> LENGTH OF STAY (in this place) <u>3 weeks</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Delaware</u> COUNTY <u>Kent</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Harrington</u> TOWN <u>Harrington</u> 46 X - 3 STREET ADDRESS (If rural, give location) <u>23 Mississippi Street</u> ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 High Street</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 9 1955</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Smith Postler</u>		5. SEX: <u>M</u> 6. COLOR OR RACE: <u>Colored</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> 8. DATE OF BIRTH: <u>Aug. 8 - 1915</u> 9. AGE last birthday: <u>73</u> yrs. <u>19</u> UNDER 1 YEAR <u>1</u> UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u> 11. BIRTHPLACE (State or foreign country): <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>John Smith</u> 14. MOTHER'S MAIDEN NAME: <u>Laura Benson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY No.: <u>—</u> 17. INFORMANT & ADDRESS: <u>Roland Postler, 126 W. Milby St, Harrington, Del.</u>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.2</u> Immediate cause (a) <u>Myocardial Chronic</u> DUE TO Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>				
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR? <u>—</u>				
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Dawson O George</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/9/55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>—</u>				
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> DATE THEREOF <u>8-12-1955</u> NAME OF CEMETERY OR CREMATORY <u>Union</u> LOCATION (City, town, or county) (State) <u>Fredonia, Del.</u>		24. FUNERAL DIRECTOR <u>(Mrs) R. H. Boyer, Harrington, Del.</u> ADDRESS <u>—</u>		
DATE REC'D BY LOCAL REG. <u>8/9/55</u>		REGISTRAR'S SIGNATURE <u>Mrs D O George</u>		

07578

BUREAU V. S.

AUG 12 1895

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH: COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>DENTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>567 HIGH ST</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED (First) <u>LEONARD</u> (Middle) <u>ALLEN</u> (Last) <u>RICH</u>	4. DATE OF DEATH (Month) <u>AUG.</u> (Day) <u>15</u> (Year) <u>1955</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 22, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER YARD LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>44</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM RICH</u>		14. MOTHER'S MAIDEN NAME <u>JULIA EMORY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-14-9150</u>	
17. INFORMANT <u>MOTHER</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>PULMONARY FAILURE</u>		
Antecedent cause(s) (b) <u>TUBERCULOSIS</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION <u>0</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>0</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>0</u>
22. I hereby certify that I attended the deceased from <u>DID NOT ATTEND</u> , to <u>OWN PAV-</u> , that I last saw the deceased <u>SICILIAN. NOT AVAILABLE</u> , from the causes and on the date stated above.		
Signature <u>Edwin B. Riley</u> (Degree or title) <u>M.D.</u>		DATE SIGNED <u>AUG 16 1955</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>Aug 20, 55</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Brook Burial</u>
LOCATION (City, town, or county) <u>Denton</u>	(State) <u>Ind.</u>	
DATE RECD BY LOCAL REG. <u>8/20/55</u>	REGISTRAR'S SIGNATURE <u>J. M. D. Thomas</u>	24. FUNERAL DIRECTOR <u>J. Virgil Moore</u>
ADDRESS <u>Denton</u>		ADDRESS <u>Denton</u>

Death occurred at home

BUREAU V. S.

AUG 30 1955

RECEIVED

7580

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
<u>X</u> TOWN <u>Rural Goldsboro</u>	<u>8 Yrs.</u>	TOWN <u>Rural Goldsboro</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>01</u> <u>None</u>		<u>None</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Carl</u>	(Middle) <u>W.</u>	(Last) <u>Schneider</u>	OF DEATH: <u>8</u> <u>14</u> <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH: <u>9/14/1893</u>
9. AGE last birthday: <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Owner</u>	11. BIRTHPLACE (State or foreign country): <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Peter Schneider</u>		14. MOTHER'S MAIDEN NAME: <u>Louise Schmidt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-8780</u>	
17. INFORMANT & ADDRESS: <u>Alfreda Schneider Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchiogenic Carcinoma</u>			<u>4 mos.</u>
ANTECEDENT CAUSE (B) <u>F.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>June 14, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bronchiogenic Carcinoma</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 20, 1955</u> , to <u>Aug. 14, 1955</u> , that I last saw the deceased alive on <u>Aug. 14, 1955</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Clark X. Fries for</u>		DATE SIGNED <u>Aug 16, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/17/55</u>		REGISTRAR'S SIGNATURE <u>Al Clark Smith</u>	
FUNERAL DIRECTOR <u>J. E. Boulain</u>		ADDRESS <u>Greensboro, Md.</u>	

BUREAU V. S.

AUG 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **07580**  
**7581** CERTIFICATE OF DEATH

Reg. Dist. No. **64**

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Caroline</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Caroline</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Seaford, Del. R. F. D.</u> 15 Yrs.			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Seaford, Del. R. F. D.</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Reliance</u>			STREET ADDRESS (If rural give location) <u>Near Reliance</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Marion Harry Tull</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Aug. 21</u> 19 <u>55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 5, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u>16</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Maryland</u>	
13. FATHER'S NAME: <u>Lewis W. Tull</u>		14. MOTHER'S MAIDEN NAME: <u>Mary E. Butler</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-61-1019</u>		17. INFORMANT & ADDRESS: <u>Mrs. Nora H. Tull, Seaford, Del. R. F. D.</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <u>177X Carcinoma of Prostate</u>					<u>3 years</u>
ANTECEDENT CAUSE (S) OUE TO <u>Gland with adenocarcinoma - skeletal metastases</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) OUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>DEC 3, 1951</u> , to <u>AUG 21, 1955</u> , that I last saw the deceased alive on <u>AUG 21, 1955</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>R. H. Beckwith M.D.</u>		DATE SIGNED <u>8/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Near Federalsburg Md.</u>		24. FUNERAL DIRECTOR <u>J. J. Frempton and Son, Federalsburg, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>August 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>			

RECEIVED

AUG 25 1955

BUREAU V. S.



7582

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

COUNTY Caroline

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

X TOWN Federalburg - Rural

LENGTH OF STAY (in this place)

4 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00 Near A merican Corner

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Caroline

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Federalburg - Rural X

STREET ADDRESS (If rural give location)

Near American Corner

## 3. NAME OF DECEASED:

(First)

Susie

(Middle)

Elizabeth

(Last)

Wade

## 4. DATE (Month)

(Day)

(Year)

OF DEATH: August 29 1955

## 5. SEX:

Female

## 6. COLOR OR RACE:

Colored

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

September 9, 1919

## 9. AGE last birthday

35

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HRS.

Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housework

## 10B. KIND OF BUSINESS OR INDUSTRY:

Home

## 11. BIRTHPLACE (State or foreign country):

Jacksonville, Florida

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Lorenza W. Slaymon

## 14. MOTHER'S MAIDEN NAME:

Joanna Jones

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

266-46-3482

## 17. INFORMANT &amp; ADDRESS:

Nathaniel Wade, Federalburg, Md., R.F.D.

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X

## IMMEDIATE CAUSE

(A)

Intestinal obstruction (colostomy)

## INTERVAL BETWEEN ONSET AND DEATH

2 months

## ANTECEDENT CAUSE (S)

DUE TO

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Metastatic carcinoma of intestine

1 year

DUE TO

(C)

Carcinoma of cervix

2 years

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

July 12, 1955

## 19B. MAJOR FINDINGS OF OPERATION

Metastatic carcinoma of intestine &amp; obstruction

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

## 21C. WHERE DID (City or town) (County) (State)

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ M. at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3, 1955, to 8-21, 1955, that I last saw the deceased

alive on

SIGNATURE

8-21, 1955

and that death occurred at 3:40AM, from the causes and on the date stated above.

ADDRESS

DATE SIGNED

Robert C. Kingsbury

M. D.

Federalburg, Maryland Aug. 29, 1955

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Aug. 31, 1955

## NAME OF CEMETERY OR CREMATORY

Liberty Chapel Cemetery

## LOCATION (City, town, or county)

Reddick, Florida

(State)

## DATE REC'D BY LOCAL REGISTRAR

August 31, 1955

## REGISTRAR'S SIGNATURE

Margaret H. Frampton

## 24. FUNERAL DIRECTOR

## ADDRESS

J.J. Frampton and Son, Federalburg, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 8 1925

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07583

7583

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Caroline</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Caroline</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Denton - Rural</b>		LENGTH OF STAY (in this place) <b>50 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Near Howard's School</b>				STREET ADDRESS (If rural give location) <b>Near Howard's School</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <b>Jacob</b>		(Middle)		(Last) <b>Zierl</b>		<b>August 2 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Sept. 15, 1895</b>	9. AGE last birthday: <b>59</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country): <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Jacob Zierl</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <b>220-09-1474</b>		17. INFORMANT & ADDRESS: <b>Mary D. Zierl, Denton, Maryland, R.F.D.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>151X Carcinoma Stomach</b>							<b>2 years</b>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19A. DATE OF OPERATION: <b>April 1954</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Carcinoma Stomach</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May</b> , 19 <b>55</b> , to <b>Aug 2</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Aug. 2</b> , 19 <b>55</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		ADDRESS <b>Denton Md</b>		DATE SIGNED <b>8-6-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 5, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>8-5-55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR ADDRESS <b>J.J. Frampton and Son, Federalsburg, Md.</b>			

BUREAU Y. S.

AUG 12 1955

RECEIVED